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ABSTRACT

A sample of 63 subassertive adults participated in four 90-minute sessions of group assertion training. The treatment components of challenging maladaptive cognitions and learning self-instructions were examined by comparing Rational-Emotive, Self-Instructional, and Behavioral Assertion Training. A delayed-treatment control group was also included. The three training groups were not found to be significantly different at posttest on self-report and behavioral measures of assertiveness. The instruments used for self-report were the Rathus Assertive Schedule, the Social Avoidance and Distress Scale, the Fear of Negative Evaluation Scale, and the Self-Assertion Scale. Generalization of treatment gains was successfully demonstrated for all three training groups on role-played scenes not previously rehearsed. However, on an "in vivo" test of transfer of training at posttest, only the Rational-Emotive group evidenced significant generalization of treatment gains. Improvements in assertiveness were shown to be successfully maintained at three-month follow-up for all three training groups. These findings were discussed in terms of the specific techniques employed to facilitate maintenance (e.g., use of personalized assertive scenes for role playing and self-monitoring during follow-up). (Author)

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Rational-Emotive, Self-Instructional, and Behavioral Assertion Training: Enhancing the Generalization and Maintenance of Treatment Gains

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Rational-Emotive, Self-Instructional, and Behavioral Assertion Training: Enhancing the Generalization and Maintenance of Treatment Gains

Treatment procedures designed to modify negative self-statements related to stressful social situations have been recently incorporated into assertion training programs (e.g., Glass, Gottman, & Shmurak, 1976; Kazdin, 1974, 1976; Thorpe, 1975; Linehan & Goldfried, Note 2; Wolfe & Fodor, Note 3). Preliminary research in other clinical areas has shown that cognitive-behavioral approaches facilitate transfer of training in the treatment of test anxiety (Meichenbaum, 1972), snake phobia (Meichenbaum & Cameron, 1974), and public speaking anxiety (Trexler & Karst, 1972). In the area of assertion training, however, the evidence has thus far been inconclusive. Kazdin (1974, 1976), for example, found that improvements in assertive-refusal behavior were maintained three months following a covert modeling procedure. Glass et al. (1976) demonstrated that increasing positive self-statements enhanced transfer of training. Wolfe and Fodor (Note 3), however, found that an RET-based approach to assertion training was not more effective than a strictly behavioral procedure in facilitating generalization of treatment effects. Further, Thorpe (1975) showed that self-instructional assertion training was more effective than a behavioral procedure at posttest and on a self-report measure of transfer of training, but not on a behavioral measure of generalization.

More recently, Linehan and Goldfried (Note 2) found that a combined therapy of rational restructuring and behavior rehearsal was more effective than either procedure used alone in the treatment of unassertive women. Further, Kanter and Goldfried (Note 1) found that rational restructuring was superior to self-control desensitization in reducing anxiety and irrational beliefs and in generalization of anxiety reduction to non-social situations.

Given the variety of therapy procedures used in the above studies, it was felt that a component analysis would shed light on the active agents of change. Thus, the purpose of the present study was twofold. First, the treatment components of repeatedly challenging negative cognitions versus learning and practicing positive self-statements were compared. Secondly, these two cognitive-behavioral approaches to assertion training were compared with a strictly behavioral approach in terms of short-term effects, transfer of training, and maintenance of treatment gains at three-month follow-up.

Method

Sixty-three subassertive adults (21 males and 41 females), representing a clinical outpatient population, were recruited via newspaper advertisement and randomly assigned to one of twelve experimental subgroups. The design was a 3 x 4 x 3 factorial (Time x Treatment x Therapist). The three levels of the Time factor were pre- and posttest and follow-up. The four experimental conditions were: Rational-Emotive, Self-Instructional, and Behavioral Assertion Training, and a waiting-list control group. The therapists were three advanced graduate students. Each conducted all three assertion training

proceduresand was blind to the experimental hypotheses.

The Rathus Assertive Schedule (RAS) was used as a self-report measure of assertiveness (Rathus, 1973). Two inventories developed by Watson and Friend (1969) were used to measure social anxiety: Social Avoidance and Distress Scale (SAD) and Fear of Negative Evaluation Scale (FNE). In addition, participants rated their own level of assertiveness on the Self-Assertion Scale (SAS) adapted from McFall and Lillesand (1971).

Behavioral measures of assertiveness were derived from role played assertive scenes at pre- and posttest. Videotaped responses were rated by two independent judges previously trained to at least .80 inter-rater reliability. Subjects role played five additional "generalization" scenes at posttest not previously rehearsed. Participants also were involved in an "in vivo" test of assertive-refusal behavior as a further measure of transfer of training. At three-month follow-up, subjects completed self-report measures of assertiveness and social anxiety. Five assertive scenes not previously rehearsed were also role played and videotaped. Finally, a telephone follow-up adapted from McFall and Twentyman (1973) was employed in which a confederate attempted to sell magazine subscriptions to participants.

Training was conducted in four 90-minute group sessions over a four-week period. The four treatment conditions were:

(1) Rational-Emotive Assertion Training (REAT). Participants in this RET-based training group were helped to identify, examine, and logically challenge maladaptive

self-statements underlying subassertiveness. They also learned and practiced positive self-statements and assertive responses.

(2) Self-Instructional Assertion Training (SIAT). Subjects in the SIAT condition learned and practiced four types of positive self-instructions: preparatory, coping, instructional, and self-rewarding. They likewise practiced overt assertive responses. No attempt was made to examine or logically challenge negative self-statements as in the REAT group.

(3) Behavioral Assertion Training (BAT). In the BAT group, assertive responses were rehearsed, modeled, and coached. Cognitive aspects of self-assertion were not overtly discussed.

(4) Waiting-list Control Group (WLC). Subjects in the WLC group were placed on a waiting list during the four-week training period and then participated in REAT during follow-up.

Pre- and post-training questionnaires were used to obtain the ratings of participants and therapists regarding treatment expectancy, perceived effectiveness of specific training procedures, therapist and group characteristics (e.g., warmth and cohesiveness), and perceived changes in assertiveness and related self-statements. In addition, the participants self-monitored real-life assertive situations and responses during follow-up.

Results

Pretest analyses revealed no significant between-group differences at pretest. Analyses of within-group changes from pre- to posttest indicated that the SIAT and BAT

groups showed significant improvements on all dependent measures. The REAT group evidenced significant gains on all but the SAD measure. The WLC group showed no significant treatment gains. The three treatment conditions were not found to be significantly different on any dependent measures at posttest. Also, no significant therapist effects were noted at posttest. In addition, ratings of treatment expectancy, adequacy of training procedures and therapist characteristics were not found to be significantly different among the experimental conditions.

Regarding transfer of training, treatment gains in role-played assertive behavior were found to be maintained on "generalization" scenes at posttest for all treatment groups. On the "in vivo" test of assertive-refusal behavior, however, only the REAT group showed significant transfer of training as compared with the WLC group, t (19) = 2.19, $p < .05$.

Follow-up data indicated that treatment effects were successfully maintained for all treatment groups. Also, no significant differences were found between groups on self-monitoring data during follow-up. Further, mean refusal scores on the telephone follow-up showed no significant between-group differences.

Individual improvements in assertiveness were also examined. At posttest, 77% of REAT participants were categorized as either "improved" or "greatly improved" along with 85% of the SIAT group and 87% of BAT subjects, while only 43% of the WLC group fell into either category. At follow-up, only 73% of the participants were tested, but all subjects in each of the treatment groups were categorized as either "improved" or "greatly improved."

Discussion

The results of the present study indicated that neither the REAT nor SIAT cognitive-behavior groups were superior to the behavioral procedure at posttest and follow-up. Only the REAT group showed successful transfer of training on the "in vivo" test of assertive-refusal behavior. But this finding provides only weak support for the importance of examining and logically challenging negative self-statements underlying subassertive behavior. The role of analyzing and modifying negative self-statements to enhance transfer of training remains to be verified in future research. In view of the apparent failure of SIAT procedures to contribute significantly to the effects of behavioral assertion training, it seems that the next empirical step is to examine which positive self-statements are effective in enhancing assertive behavior and which are not with particular individuals.

The treatment effects in the present study were not only maintained for the two cognitive-behavioral groups, but also for the BAT condition. It is possible that the use of self-monitoring during follow-up contributed to successful maintenance across treatment conditions, although this point needs to be verified in future research.

Schwartz and Gottman (1976) obtained preliminary evidence supporting the role of both positive and negative self-statements in assertive behavior and social inhibition. While the present results generally failed to support the contributions of cognitively-oriented treatment procedures in assertion training, the role of cognitions in assertive behavior cannot be discounted. For example, it might be hypothesized that the self-monitoring procedures employed during follow-up had an impact on self-statements

related to assertive behavior. Given the recent success of behavioral assertion training in achieving maintenance of treatment effects (Galassi, Kostka, & Galassi, 1975), it would appear to be particularly beneficial to examine changes in cognitions resulting from orthodox behavioral approaches to assertion training. In addition, future research is needed to determine the training procedures most effective in modifying self-statements related to social anxiety and self-assertion.

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